IN THE SUPREME COURT OF THE STATE OF MONTANA

Supreme Court No. DA 09-0682

JEANETTE DIAZ, LEAH HOFFMANN-BERNHARDT, RACHEL LAUDON, individually and on behalf of others similarly situated, Plaintiffs/Appellants, vs. BLUE CROSS AND BLUE SHIELD OF MONTANA, NEW WEST HEALTH SERVICES, MONTANA COMPREHENSIVE HEALTH ASSOCIATION, STATE OF MONTANA, AND JOHN DOES 1-100, Defendants/Appellees.	Lower Court Cause No. BDV 2008-956 Honorable Jeffrey Sherlock

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I. ORGANIZATION OF THIS REPLY

The Appellants believe their attempt to certify the class has been needlessly complicated and fragmented by the Respondents' arguments. Therefore, the brief first re-focuses on the relevant circumstances. It then addresses each of the Respondents' arguments in this context.

II. PURPOSE OF THIS CLASS ACTION

The following is based upon the initial complaint, which must be taken "as true [with] any doubts as to certification . . . resolved in favor of the plaintiffs." *Thompson v. Community Ins. Co.*, 213 F.R.D. 284, 291 (D. Ohio 2002). It is also based upon the limited evidentiary record compiled through discovery, which is still in its preliminary stages, and the admissions in the transcript of the certification hearing.

1. The Legal Basis. As stated in *Blue Cross Blue Shield v. Montana State Auditor*, 2009 MT 318, ¶ 19, Montana's "made whole" laws prohibit a health insurer from "avoid[ing] payment of benefits to its insured" based upon the insured's "entitlement to" compensation from a tortfeasor. This practice is an illegal form of subrogation because it "effectively allow[s an insurer] to exercise subrogation before paying anything to its insured, contrary to § 33-30-1101, MCA."

2. The State is Employing This Practice. The State admits it employs this practice through *all of its plans*. The administrator of the State's insurance program testified at the certification hearing as follows:

> Q In fact, you have a provision in your State policy saying the State will not pay . . . for medical costs if they're paid by the third-party liability carrier, do you not?
>
> A That is correct, we have an exclusion.
>
> Q And you enforce that exclusion.
>
> A We do.

Tr. 200-201. This practice is memorialized in the State's Summary Plan Document, "Exclusions and Limitations," p. 57, ¶ 5 (*See* Internet). It is not a "coordination of benefits" as mischaracterized by the State. It is an "exclusion." State's Brief, p. 8.

This practice is carried out for the State by its third party plan administrators, Blue Cross Blue Shield of Montana ("BCBSMT") and New West. They use their computers to determine when an insured may have another source for paying medical costs. They then send out a letter to determine if a tortfeasor is involved and suspend all payments of benefits in the interim. If the insured's response indicates a tortfeasor's liability carrier is potentially responsible for paying medical expenses as part of tort damages, then the administrators terminate all benefits, allowing the tortfeasor's liability carrier to pay first. *See e.g.*, Tr. 111-114, 149-153. Thousands of letters have gone out over the past eight years and

hundreds have come back indicating another source of payment. Tr. 151-153. The State's administrator testified that the State has avoided $34 million dollars in benefit payouts using this practice, albeit only a fraction would be attributable to situations involving tortfeasor payments.[1] Tr. 189-194, 205-207.

As discussed in *Montana State Auditor, supra,* this practice has also been employed by BCBSMT in its own plans. In *Neary et. al. v. BCBSMT*, Cause No. DV-08-553, BCBSMT has admitted it has avoided payment to 3,585 insureds by relying on the tortfeasor to pay, reducing benefit payouts by over $5,000,000. *See* Appellants' Opening Brief, Appendix 9.

There is currently little evidence concerning the extent to which New West employs this practice with its insureds. Discovery, however, has hardly begun and at this stage, the allegations in the Appellants' complaint must be taken as true.

A *defacto* form of this practice occurs when the medical provider bills the tortfeasor rather than the health insurer. A court can enjoin this practice by requiring the Respondents to notify all preferred medical providers to bill the Respondents first whenever there exists a tortfeasor source of payment.

The Respondents make the incredible statement that their insureds

[1]The practice of avoiding payments based upon a source of payment from the tortfeasor or UM benefits is the only practice being challenged. Coordination of benefits involving medicare, and other first party benefits are not challenged and we assume make up the bulk of the $34 million.

sometimes prefer having the tortfeasor pay first. This is tantamount to contending injured people would knowingly decide to enrich their health insurer, rather than have money available to pay for all of their damages. The situation can be corrected by ordering the Respondents to notify their insured of their "made whole" rights – instead of providing them with an "exclusion" which states they have none. At the same time, the Respondents can notify their insureds that if they believe their "made whole" rights have been violated because the tortfeasor paid medical costs, they may be entitled to reimbursement from their health insurer.

3. The Appellants Are Victims of this Practice. In their briefs, the Respondents have improperly construed all evidence in their favor to make it appear as if the Appellants have not been harmed by this practice. The evidence and allegations, however, show the Respondents have avoided paying benefits to the Appellants because a tortfeasor was available. The Respondents have yet to make any made-whole determinations.

When Ms. Diaz was injured, BCBSMT sent her one of the computer generated "coordination of benefits" letters and suspended payment in the interim.

The State, through BCBSMT, then allowed the tortfeasor's liability carrier to pay medical expenses. Ms. Diaz's attorney, Jim Hunt, demanded that Ms. Diaz be reimbursed, since she had not been "made whole." No made-whole determination was ever made. No reimbursement has occurred." *See* DN 50, Attachments 2, 3, 4, and 6.

When Ms. Hoffmann-Bernhardt was injured, both the State and the tortfeasor's liability carrier initially commenced paying medical bills. The medical providers reimbursed the State and used the tortfeasor's money to pay the medical expenses. Then the State stopped paying benefits, allowing the tortfeasor to pay. (Obviously, the State and its administrator, New West, knew full well the tortfeasor was paying and no "made-whole" determination had been performed.) When Ms. Hoffmann-Bernhardt's attorney complained, New West responded, "Everything billed to New West was refunded and billed the auto ins." DN 50, Attachments 2, 8.

4. The Class Action. Thus, Appellants have brought this class action to enjoin an illegal insurance practice, which the State admits continues to this day with the help of its third party administrators. The complaint alleges the third party administrators programmatically employ the same practice with their own insureds, which also should be enjoined. As shown above, there already exists strong

evidence these allegations are true.

Montana Rule of Civil Procedure 23(a) defines what constitutes a legal class: It is a group of people who have at least one common issue which links them and who are represented by plaintiffs whose interests are typical to those of the class in such a way that by pursing their individual claims, the representatives cannot help but further the class's interests. If joinder of the group is impracticable and if the representative plaintiffs have competent counsel, then the group is entitled to pursue a class action. Such a class exists here. There are probably hundreds of people who have at least two common issues linking them:

(1) Common factual issue: Have the Respondents programmatically carried out a practice which avoids payment of benefits to those who also have a tortfeasor source for payment of medical expenses– without the Respondents first making a made-whole determination?

(2) Common legal issue: Is it illegal for the Respondents to carry out this practice without first making a made-whole determination?

The Appellants, as representative plaintiffs, have interests typical of those of the class: If they can show it is illegal to conduct this practice without first making a made-whole determination, then they prevail on their claims and so does every other member of the class. If they do not prevail on this issue, then neither does the class. Thus, the class and the representative plaintiffs have the same basic

interests in common, assuring the class will be adequately represented. Since Rule 23(a) is satisfied, a class legally exists.

The second requirement for class certification is a manageable remedy under Rule 23(b). To avoid individualized factual determinations, which could create "mini trials," the Appellants are not asking that the Respondents be ordered to perform "made-whole" determinations. Rather, they are requesting only that the practice of avoiding benefits without performing this determination be enjoined and that those who have had their benefits curtailed be paid the same amount the Respondents would have been required to pay had they not engaged in this illegal practice. This is the same remedy found appropriate in *Ferguson v. Safeco*, 2008 MT 109:

> Ferguson requested "an injunctive order compelling the return of subrogation amounts ***until such time*** as adjustments under the "made-whole" standard have been completed by Safeco." ***She did not seek "adjudicate any individual 'made whole' entitlement***."
>
> The case, therefore, did "not require the court to analyze any individual insured's amount of loss or recovery. Rather, the relief sought by Ferguson on behalf of the class is an order compelling Safeco to properly perform its statutory adjustment duties.

Id. at ¶¶ 33, 39 (emphasis added). Therefore, as in *Ferguson*, the Appellants have shaped a manageable remedy under Rule 23(b)(2).

If the Respondents believe they have a subrogation interest, they still will have the option and duty to perform a "made-whole" determination, *but only after the class action is de-certified– not as part of it.* They can then adjust the benefits, if the insured has been made whole. If the Respondents insist the determination must be made part of the class action, then certification under Rule 23(b)(3) should be considered with appropriate procedural tools employed to make the remedy manageable. *See e.g., Burton v. Mt. W. Farm Bureau*, 214 F.R.D. 598 (D. Mont. 2003).

Therefore, the Appellants are entitled to a class certification.

III. THE RESPONDENTS' CONTENTIONS

It is in this context the Respondents' allegations should be analyzed.

A. BCBSMT CONTENTIONS IN *NEARY*.

On page four of its brief, BCBSMT characterizes *Neary v. BCBSMT*, Cause No. DV-08-553, as "irrelevant to the subject matter." This contention is addressed first because it is both incorrect and because BCBSMT's conduct in *Neary* affects many of the Respondents' contentions.

The subject matter in *Neary* and this case is virtually identical. The class in both are requesting restoration to full benefits because the insureds have avoided benefits without conducting "made-whole" determinations. In *Neary*, this is based

upon BCBSMT exclusions declared in violation of the "made-whole" laws through *Montana State Auditor, supra*. Appellants' Reply Brief Appendix 1, pp. 2-3. Here, both BCBSMT's exclusions and the State's exclusion memorialize the existence of the same practice.

The putative classes overlap: Diaz contains both BCBSMT and State plans. *Neary* contains the same BCBSMT plans, but according to BCBSMT, does not contain State plans.[2]

The reason *Neary* is relevant is because BCBSMT's positions there contradict its positions here. In *Neary*, where it stands to gain a settlement which significantly compromises its obligations to its insureds, BCBSMT has advocated for certification. By contrast here, where the rights of the class are being zealously represented, BCBSMT argues certification should not be granted for virtually every conceivable reason.

BCBSMT's contradictory positions will be discussed in more detail throughout this brief. In *Kauffman v. Kauffman*, 307 Mont. 45, 50-51, 36 P.3d 408, 412 (Mont. 2001), this Court stated:

The fundamental purpose of judicial estoppel is to protect the integrity

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[2] In *Neary*, BCBSMT has taken the position: "The class definitions proposed in [*Neary*] do not, and never did, encompass Ms. Diaz's claims against BCBSMT. . . . . [Neary] does not interfere with Ms. Diaz's ability to protect those distinct claims in the state court." Reply Brief Appendix 2, p. 17. It makes a similar assertion in its appeal brief here, p. 8.

> of the judicial system and thus to estop a party from playing "fast and loose" with the court system. [citations omitted] Hence, the doctrine of judicial estoppel binds a party to his or her judicial declarations, and precludes a party from taking a position inconsistent with previously made declarations in a subsequent action or proceeding. [citations omitted].

Either BCBSMT should be estopped from taking contradictory positions here or at the very least, its positions should be given little weight.

B. A"MADE-WHOLE" DETERMINATION IS NOT REQUIRED.

1. All Respondents. Throughout their briefs on a variety of issues, the Respondents continue to erroneously assert this class action requires individual factual assessments and mini trials on "made-whole" determinations. For the reasons set forth in the above summary and in *Ferguson, supra* at ¶¶ 33, 39, this is untrue. *Ferguson* simply requires the insurer to conduct a "made whole" determination before enforcing subrogation. Appellants request the same here.

2. BCBSMT in *Neary*. The class BCBSMT endorsed in *Neary* says nothing about BCBSMT making made-whole determinations. Concerning calculation and payment of benefits, BCBSMT represents:

> "[E]ach putative Class Member, after receipt of notice, would ***only need*** to have their submitted claims readjusted (or, if allowed, submit their medical claims if they were not submitted previously). ***This is a ministerial process and no further court action should be necessary.***"

Appellants' Reply Appendix 2, p. 16 (Emphasis added). This is virtually identical to the reasoning that supported certification under Rule 23(b)(2) in *Ferguson*, *supra* at ¶ 35: "*There will be no analysis for the court to do . . . [because] it will be left to the [insurer] to adjust insurance claims in accordance with claims procedures already in place*." (Emphasis in text). This is precisely the remedy the Appellants have requested here.

C. STATE INSURERS AND PRIVATE INSURERS ARE SUBJECT TO THE SAME "MADE-WHOLE" REQUIREMENTS.

1. All Respondents. If this Court chooses to reach the issue, the State is subject to the same "made-whole" laws as private carriers for reasons set forth in the Appellants' Opening Brief, pp. 30-38. Basically, both are subject to identical subrogation statutes, incorporating the made-whole laws. The cases Respondents cite are distinguishable on this and other bases.

In its response brief, however, the State asserts it is exempt from the "rigors of Title 33" governing insurance. This may be true for some aspects of its insurance program, but not for its "made-whole" obligations. The legislative history shows the State asked to be treated the same as private insurers on this subject.

In 1987, the legislature passed § 33-30-1102, MCA, giving private insurers

limited subrogation rights which by the statute's language "*may not be enforced until the insured has been fully compensated.*" Fearing it would be left out, the State lobbied for an identical statute under Title 2. The person in charge of the Employee Benefits Bureau gave the legislature the following explanation:

> Because the State's Self-Insured Plan is exempt from Title 33, the State Plan would not be allowed to subrogate. I would like to offer an amendment for your consideration which would also allow the State Self-Insured Plan the option of including a subrogation provision.

Appendix 3 to this Reply Brief. The legislature granted the State's request, simultaneously passing identical subrogation statutes for both Title 2 and Title 33 insurers at § 2-18-902, *supra* and § 33-30-1102, *supra*.

The State's actions in 1987 are significant. First, the State admits it had no subrogation rights whatsoever before the statute – contrary to its position now that it has subrogation rights not subject to "made-whole" laws. Second, the State advocated for a statute that defines it as an "insurer" and state employees as "insureds"– contrary to its position now that it should not be characterized as such. Third, the State asked to be included in a law which expressly recognizes the insured has a right to full compensation before the insurer can benefit from the tortfeasor recovery– contrary to its current position that it should be treated differently.

2. BCBSMT in *Neary*. BCBSMT sees no problem combining plans that could be subject to different laws. It represents it is permissible to combine plans governed by state law with plans governed by federal law through the Employee Retirement Income Security Act of 1974 (ERISA). *See e.g.*, Reply Appendix 2, *supra.*

D. THE RESPONDENTS' RENDITIONS OF THE FACTS ARE INACCURATE.

Apparently in an effort to persuade, all Respondents label as "facts" evidence which at the very least is in dispute, subject to further discovery and subsequent factual findings by the courts. A few examples follow.

1. The Administrators' Attempts to Distance Themselves. Both BCBSMT and New West attempt to portray themselves as simply "processing agents" for the State. This, however, is contradicted by evidence of deep involvement in the practice in question, including programming and employing their own computers to assist the State in carrying out this practice, reducing coverage when a tortfeasor is available and keeping records on how successful the practice has been. *See e.g.*, Tr. 206-208. After certification, there will be additional discovery concerning the extent of BCBSMT's and New West's involvement and their potential responsibility under other causes of action, but in

the meantime, the allegations of the Appellants' complaint control and indicate joint involvement among all Respondents.

The State also misconstrues the evidence and allegations. It argues, for instance, that the Appellants lack standing to sue other State plans which might have different provisions. The Appellants, however, are contending the State programmatically avoids payment when a tortfeasor is present in *all* of its plans and the Appellants' allegation must be construed as true for certification. Moreover, the State's allegation lacks any evidentiary foundation. As shown by the documented summary, *supra*, the administrator of the State's insurance program has admitted the State employs this practice across its program in *all* plans. This also appears to be admitted at page seven of the State's brief, which lists "exclusion ¶ 5" in the State's Summary Plan Document, *supra*, and applies to all State employees.

2. The State Employees Pay for Their Health Insurance. The State attempts to create the impression it does not collect premiums from public employees. The premiums, however, are part of the employees' compensation as benefits negotiated through the employees' collective bargaining agreement. Retirees and dependents, who do not work for the State, also pay premiums. *See e.g.*, State's Brief, p. 5. At any rate, how the premiums are paid is irrelevant and

confuses the issues, since the State is subject to the same subrogation and "made-whole" laws statutorily imposed on private carriers. *See* discussion, *supra*.

3. Rachel Laudon. To further confuse the issues, the State argues this Court should consider Rachel Laudon's claims against MCHA. Those claims are irrelevant because Laudon settled before the certification hearing, even if formal court approval did not occur until later. Indeed, at the beginning of the certification hearing, MCHA's lawyer was "excused for the remainder of the hearing" because Laudon had "entered into a settlement agreement with MCHA." Tr. at 46.

4. *Ad Hoc* Settlements. The State argues *ad hoc* settlements with some insureds should preclude a class action on behalf of any of its insureds. Persons who have settled will not be within the class precisely because they have settled any contention the State illegally avoided coverage.

5. Blue Cross in *Neary*. Respondents contend they have no way of identifying situations where the medical provider bills the tortfeasor first without informing the Respondents. Blue Cross, however, has taken the position in *Neary* that these "unsubmitted claims" can be included in a class action and identified through proper notice. *See* Reply Appendix 2, p. 6 (subclass (d)).

(As set forth in the summary in Part II, *supra*, the Court can devise orders to notify this "unsubmitted claims" group of their "made-whole" rights and to prevent health insurers in the future from mistakenly billing tortfeasors.)

E. AMENDED COMPLAINT.

Since the District Court has never ruled on the motion to amend, the proposed amended complaint cannot procedurally and legally affect this appeal. The Appellants are entitled to have their motion considered; if granted to respond to any arguments the Respondents have against it and then to decide whether all or part of the amended complaint should be within the certified class action. Both the lower court and this Court are entitled to have a complete record on this matter before considering its potential effect on certification. Therefore, it would violate procedural due process to consider the amended complaint now.

F. THE CLASS DEFINITION IS ADEQUATE.

Contentions that the class definition is inadequate lack merit.

1. Class Definition Has Limited Utility. There are "no formal rules govern[ing] a class definition." 2 *Newberg on Class Actions, supra* at § 6:15, p. 620. There is nothing in Mont.R.Civ.P. 23 indicating one is required (Federal Rule 23 is different, having been amended in 2003). A class definition is "not very helpful" at the certification stage. Rule 23(a) criteria already define a class.

Therefore, the "parties and the court should properly focus on Rule 23 criteria rather than on any such initial inquiry." 1 *Newberg, supra* at § 2:4, p. 74. "Amorphous class definitions, in actions seeking declaratory or injunctive relief, may properly be utilized to describe the class of affected persons." 2 *Newberg, supra* at § 6:15, p. 627.

2. The Appellants Provided an Adequate Definition. When the Respondents attacked the class definition in the lower court, the Appellants provided the following in their reply brief on certification:

> "Simplistically, the class could be defined as 'all persons covered by the Defendants who were deprived of benefits because there was a third party [tortfeasor] source of payment of medical expenses.' To avoid unnecessary debate, however, the Plaintiffs are willing to define the class in a manner virtually identical to the *Ferguson* class."

DN 39, p. 8. The Appellants set forth a detailed definition in a table, comparing their definition to the one given in *Ferguson, supra*. It is reproduced immediately below:

Ferguson class, see 208 MT 109, ¶7	Diaz, et al., class
a. "Insured under an auto insurance policy issued by Safeco Insurance Company of America or any of the Safeco Companies in Montana."	a. Insured (or covered) for health care costs under policies and plans owned or operated by the Defendants. See opening brief, p. 5.
b. "Who, as a result of an auto accident, suffered expenses covered by such policy . . ."	b. Who, as a result of an event, suffered medical expenses covered by such policies or plans. See opening brief, p. 4.
c. "Who received payments under the coverages of such policy"	c. Who legally should have received payments under such policies or plans. See opening brief, p. 5.
d. The Defendants "recovered from a third party subrogation for some or all of such payments"	d. The Defendants failed to pay benefits or reimbursed themselves for payments because a third party was also responsible for payments as damages. See opening brief, p. 4.
e. "Whose claim arose not more than eight (8) years preceding the filing of the Complaint in this action."	e. "Whose claim arose not more than eight (8) years preceding the filing of the Complaint in this action."
Not applicable	f. Who are insured by policies or plans governed by Montana law and not subject to federal preemption arguments, such as federally governed ERISA plans, military health plans or union plans.

Id. at p. 7. The same class was described at the certification hearing and was narrowed further by adding a requirement the defendants "did not determine if [any] insured was made whole" before avoiding benefits. Moreover, the

Appellants explained the "third party" source of payment consisted solely of insurance available to pay for a tortfeasor's damages. Tr. 36-37, 378-379, 390.

This is an adequate description. It is not only consistent with *Ferguson, supra*, but more exacting than the one in *Polich v. Burlington Northern, Inc*. 116 F.R.D. 258, 261 (D. Mont.1987). It allows the Court to identify who is within the class:

(1) It starts off with all those insured by Respondents.

(2) It then narrows to only those who have been injured by a tortfeasor.

(3) It narrows further to include only those where the Respondents have avoided paying benefits because a tortfeasor was available to pay.

(4) Finally, it narrows to only those where the Respondents failed to conduct a "made-whole" determination before avoiding benefits.

Based upon the admissions of the Respondents' officials at the certification hearing, this would probably be a group of hundreds of people with regard to the State. Based upon BCBSMT's admissions in *Neary, supra*, this would probably include over 3,000 BCBSMT insureds.

In summary, assuming a definition is needed, the Appellants' is adequate.

3. The State's Attacks. The State argues the class definition allows for too many dissimilarities among class members. The degree to which there needs to be common circumstances, however, is determined by the "commonality" criteria of Rule 23(a)(2) – not by the class description. Therefore, it will be addressed below when discussing commonality.

The State argues the Appellants are not members of the class which they define because they have sued on behalf of members of other State plans and on behalf of New West and BCBSMT insureds. This is an issue properly covered within the "typicality" analysis and therefore, likewise, will be addressed subsequently.

The State argues the class definition should be limited to a single practice. Although this would not seem relevant to a class description, suffice it to say that Appellants are pursing one practice consisting of (1) avoiding paying benefits, (2) when a tortfeasor is available to pay and (3) without making a made-whole analysis.

4. BCBSMT's Attacks. BCBSMT attempts to limit the Appellants to the class definition preliminarily given in the complaint, rather than the one actually used by the Appellants during the certification process. The same confusion was created by the defendants in *Ferguson, supra*. As noted in Ferguson's reply brief

to this Court:

> In order to create the appearance of class identification problems, Safeco points, not to the definition in the motion for class certification, but to the description of the relief class in the complaint. But it is the motion's definition which is at issue on this appeal.

Ferguson reply brief, p. 2; http://mtlawlibrary. Ultimately, this Court agreed, adopting Ferguson's definition as developed on motion for certification, rather than the definition in the complaint. *See Ferguson, supra* at ¶ 7. Class definitions are often redefined and modified throughout the litigation. *See e.g.*, 1 *Newberg, supra* at § 2:3, p. 55.

Since BCBSMT attributes a class definition to the Appellants different from the one actually used at the certification hearing, their criticisms of the wrong definition *per se* lack merit.

BCBSMT arguments that the definition requires "mini trials" and that the amended complaint is relevant lack merit for the reasons set forth previously.

5. New West's Attacks. New West, likewise, creates a strawman by attacking class definitions different than the one used by the Appellants and essentially duplicates arguments made by the other Respondents.

G. NUMEROSITY EXISTS.

1. All Respondents. The Respondents challenge the District Court's conclusion that numerosity was probably established. Order, p. 16. As displayed by the documented summary in Part II, *supra*, the District Court's conclusion is correct.

2. BCBSMT in *Neary*. BCBSMT has made admissions in *Neary*, *supra*, which provide both direct and circumstantial evidence that numerosity is clearly established. It has identified thousands of BCBSMT insureds who would fall within the class. Moreover, in the list it provided in *Neary*, BCBSMT identified 961 people who are "gov't fully insured," resulting in $1,267,712.36 in avoided benefits. Appellants' Opening Brief, Appendix 9. The largest "gov't fully insured" program in Montana is probably the one operated by the State, which is part of this lawsuit. Therefore, it is fair to assume that the majority of the 961 people identified as "gov't fully insureds" are those in the State's program.

State employees have been included in the *Neary* list. BCBSMT recently notified Ms. Diaz that she is a member of the *Neary* class. This shows she is one of the persons on this list. Appellants' Reply Appendix 1. We assume, however, BCBSMT unintentionally sent the notice out to those insured by the State because it previously represented neither Ms. Diaz nor those insured by the State are in the

Neary class. See Reply Appendix 2, p. 17. Nevertheless, the list BCBSMT created in *Neary* shows many State employees fall within the class here.

H. COMMONALITY EXISTS.

1. All Respondents. Respondents content differences among the class members defeat the commonality prerequisite of Rule 23(a)(2). Differences among class members, however, will not defeat commonality under the current circumstances for the following reasons.

In *Ferguson, supra,* this Court fully explored what is necessary to establish commonality where, as here, the plaintiffs are contending insurers are systematically employing an illegal insurance practice:

- "[R]egardless of differences among class members, this element is met if a single issue is common to all. *McDonald v. Washington,* 261 Mont. 392, 401, 862 P.2d 1150, 1155 (1993)." *Id.* at ¶ 16.

- "[T]he common issue for class certification [can be] whether the defendant breached a duty owed to all class members." *Id*. at ¶ 21 (citing *McDonald*).

- "Commonality is satisfied when the question of law linking class members is substantially related to resolving the litigation, *even though individuals may not be similarly situated*. Similarly, commonality will also be satisfied when there is a common core of salient facts coupled with disparate legal remedies within the class. The nature of the plaintiffs' claim is directly relevant in determining whether the matters in controversy are individual or suitable as a class action." *Id.* at ¶ 23.

- "The commonality requirement is not a stringent threshold and does not impose an unwieldy burden on plaintiffs. In fact, as a general rule, all that is necessary to satisfy Rule 23(a)(2) is an allegation of a standardized, uniform course of conduct by defendants affecting plaintiffs. Plaintiffs need only show a "common nucleus of operative facts" to satisfy Rule 23(a)(2)." *Id*. at ¶ 26.

- "Where a common scheme of deceptive conduct is alleged, common questions of law and/or fact will exist." *Id.* at ¶ 27 (citing *Powers v. Government Employees Ins. Co*., 192 F.R.D. 313 (D. Fla. 1998) as a case "on point).

This Court, therefore, concluded Ferguson satisfied commonality by alleging the insurer "engaged in 'a common scheme of deceptive conduct,' by taking subrogation recoveries without an investigation into and determination of whether the insureds have been made whole." *Id.* at ¶ 28.

The Appellants, here, have satisfied the commonality requirements for the same reason. As in *Ferguson*, they allege the insurers "engaged in 'a common scheme of [unlawful] conduct,' by taking subrogation recoveries without an investigation into and determination of whether the insureds have been made whole." (As ruled in *Montana State Auditor, supra* at ¶ 19, "subrogation" includes "avoid[ing]" coverage by having the tortfeasor pay first.) Commonality is not a "stringent threshold" under these circumstances and application of the above *Ferguson* rules covers all of the nuances the Respondents raise in their briefs.

2. BCBSMT in *Neary*. In *Neary*, as opposed to its position here, BCBSMT represented "certification of a class cannot be defeated for lack of commonality solely because there are some factual variations among the claims of individual class members." Moreover, the existence of multiple plans and even multiple insurance agreements do not defeat commonality. "The important question for purposes of the Parties' settlement is whether each Class Members claim arises from the same act by defendant." Appellants' Reply Appendix 2, pp. 11-12. As set forth in *Ferguson, supra*, the same applies here.

I. TYPICALITY.

1. All Respondents. Respondents basically argue typicality does not exist because the Appellants lack standing to sue on behalf of plans other than their own. For a variety of reasons, their contentions lack merit.

2. The Respondents Have Waived the Right to Make Any Standing Arguments. A Respondent "waive[s] the right to present . . . claims . . . on appeal," where the lower court neither ruled upon them nor the Respondent made a cross appeal. *Revelation Industries, Inc. v. St. Paul Fire & Marine Ins. Co.*, 2009 MT, 350 Mont. 184, 199, 206 P.3d 919, 929 (Mont. 2009). Similarly, if a Respondent believes a portion of the District Court's order is deficient, it must

cross appeal or this Court will "decline to consider [its] challenge." *Alexander v. Bozeman Motors, Inc*., 2010 MT 135, ¶ 11, n. 3.

Here, the District Court did not make any rulings on standing. The only reason it gave for holding typicality had not been established was its erroneous conclusion that "mini trials" would be necessary. Order, p. 16. The Respondents have made no cross appeals. Therefore, the issue of standing has been waived. Appellants' complaint alleges a joint practice by all Respondents and it must be construed in favor of the Appellants. *Thompson, supra*.

3. Typicality Exists Regarding the Appellants and the State. The State relies upon *Murer v. Montan State Comp. Mut. Ins Fund*, 257 Mont. 434, 849 P.2d 1036 (1993). *Murer* has nothing to do with this case. There, the plaintiffs were suing every workers' compensation insurer in the industry although they only had a relationship with two of them. This Court held that "plaintiffs are not entitled to bring a class action against defendants with whom they have had *no dealings*." 849 P.2d *supra* at 1038 (emphasis added). That is not occurring here. The Appellants have direct "dealings" with the State's insurance program.

Moreover, the argument that different State plans might have different contractual language lacks merit. The administrator of the State's insurance program admitted at the certification hearing that *all* State plans enforce a written

provision, which requires the tortfeasor to pay before the State will pay. That is the practice which is the gravamen of this suit.

Typicality between the Appellants and the State, therefore, is established for several reasons. The Appellants have direct dealings with the State. They are suing the State – not its plans. Alleged differences between plan provisions are irrelevant, where, as here, the State admits it engages in the alleged illegal practice throughout its program in all of its plans. *See Ferguson, supra.*

4. Typicality Between the Appellants and BCBSMT and New West.

As a practical matter, whether or not typicality is satisfied against BCBSMT and New West may not be important. There are two suits pursuing a class action against BCBSMT concerning this practice. *Budd and Pallister v. BCBSMT*, CV-09-25-BU-SEH (D. Mont) and *Neary, supra*. There is at least one class action against New West for the same practice. *Rolan v. New West*, First Judicial District, CDV-2010-91. Thus, regardless of how this Court rules, the systematic practices of BCBSMT and New West is being addressed elsewhere. Respondents' contentions are addressed below.

In general, BCBSMT and New West allege they are merely the administrators of the Appellants' plans, and therefore, the Appellants' interests are

not typical of people they directly insure. They rely primarily on *Murer, supra,* and *LaMar v. H&B Novelty and Loan Co*, 489 F.2d 461 (9 Cir. 1973) for the proposition that plaintiffs cannot bring a class action against defendants with whom they have had no dealings.

This is not a case, however, where the plaintiffs have no "dealings" or relationships with the defendants. As both alleged and shown by evidence, Diaz has direct dealings with BCBSMT involving the precise practice she believes illegally deprived her of benefits. Hoffmann-Bernhardt has the same type of relationship with New West. Thus, cases like *Murer* and *LaMar* are not decisive.

The Appellants have not located any cases which exactly fit this situation either. However, there is no logical basis for denying typicality exists against BCBSMT and New West. There have been direct dealings between the Appellants and Respondents involving the insurance practice at issue and the Appellants allege BCBSMT and New West have employed the same practice in their own plans. The purpose of typicality is to assure typical interests exist between the representative plaintiffs and the class so that by protecting their own interests, the representatives cannot help but protect the class's interests. *General Tel. Co. v. Falcon,* 457 U.S. 147, 158 (1982). As set forth above, the only way the Appellants can prevail is by proving the Respondents have employed an unlawful insurance

practice. If they prevail, the class prevails. Thus, typical interests are present.

In *Ferguson*, *supra*, this Court determined that *Powers*, *supra*, was a "case on point." *Powers* rules typicality "is established if the claims or defenses of the class and the class representatives arise from the same event, *pattern or practice and are based on the same legal theory*." 192 F.R.D. *supra* at 317 (emphasis added). Applied here, the Appellants are alleging they and the class have been harmed by the same "pattern or practice . . . based on the same legal theory." Specifically, BCBSMT and New West have been avoiding coverage without making a "made-whole" determination first.

Typicality is not a "demanding" criteria. *E.g. Bittinger v. Tecumseh Prods. Co.*, 123 F.3d 877, 884 (6 Cir. 1997). Where, as here, the representative plaintiffs have direct dealings with the defendants and interests typical of the defendants' own insureds, they have met the requirements of typicality.

Regardless of how this Court rules, BCBSMT and New West will remain part of the suit for several reasons. They are necessary parties to the declaratory judgment action:

> When declaratory relief is sought, all persons *shall be made parties* who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding.

Section 27-8-301, MCA (emphasis added). Here, it is hard to imagine how New West and BCBSMT would not be necessary parties given their deep involvement in the practice that has deprived both the Appellants and State class members of their full benefits. (The matter is fully briefed in the District Court, but no decision has been made.)

Even assuming typicality against these two does not exist now, it could be established by subsequent events. Additional class representatives could be joined who are directly insured by these two Respondents. As stated in *LaMar, supra* at 468, "it may well be that a representative plaintiff injured by each defendant may emerge to undertake the burden . . . ." Furthermore, when the amended complaint is eventually ruled upon, it may establish direct tort claims between the Appellants and these two Respondents and thus, establish typicality on a different ground. As indicated in *LaMar, supra* at 466, a "cause of action" against the defendants should establish typicality.

5. BCBSMT in *Neary*. In *Neary*, the two representative plaintiffs have connections with only two plans. Nevertheless, they are suing on behalf of members of *every* BCBSMT plan in Montana -- including plans governed by state law and plans governed under federal law. In *Neary*, BCBSMT represented

typicality existed for the following legal reasons:

- There need only be a "sufficient nexus between the injury suffered by the plaintiffs and the injury suffered by the class."

- "A named plaintiff's claim is typical if it stems from the same event, practice or course of conduct that forms the basis of the class claims and is based upon the same legal or remedial theory."

- Typicality "refers to the nature of the claim of the class representative and not to the specific facts from which it arose or the relief sought."

- "There is no requirement, however, that the class representative have circumstances identical to those of the proposed class members."

Appellants' Reply Appendix 2, p. 12. This contradicts BCBSMT's position here and supports the Appellants' position.

6. Summary on Typicality. Typicality clearly exists between the Appellants and the State. There is no logical reason why typicality should not exist against BCBSMT and New West, but even assuming, *arguendo*, it does not, BCBSMT and New West necessarily would remain parties to the lawsuit in some capacity. If typicality exists against all Respondents, possible management problems can be resolved by creating subclasses under Mont.R.Civ.P. 23 (c)(4).

J. ADEQUATE REPRESENTATION EXISTS.

The Appellants stand on their position set forth in their Opening Brief, pp. 23-24.

K. A MANAGEABLE REMEDY EXISTS.

Appellants stand on the position taken in their Opening Brief at pages 24-27. As shown in the summary at Part II, *supra*, this class action attempts to enjoin and correct a single type of insurance practice where the Respondents avoid coverage without making a made-whole determination. It is conceptually the same as *Ferguson, supra*. If not, Rule 23(b)(3) provides an appropriate alternative as was done in *Burton, supra*. If a manageable remedy exists in *Neary,* as BCBSMT represents, then a manageable remedy exists here. The Respondents' contentions are addressed below.

1. Alleged Factual Disputes. All Respondents argue the relief will require factual determinations. As recognized in *Ferguson, supra* at ¶¶ 34-36, however: The "class claims do not seek a determination of entitlements for each class member and the payment of damages: rather, [the] claims seek a declaratory ruling that will be enforced by compelling the [insurer] to follow the legal standard in its subrogation program." This "does not require the court to analyze any individual

insured's amount of loss or recovery." It just requires the insured to perform their duties in a lawful manner. As admitted by BCBSMT in *Neary*, a remedy will not require "mini trials."

2. Allegations in the Amended Complaint. For reasons previously stated, the amended complaint is not ripe for consideration.

3. Statutory Aspect of Case. For reasons previously stated, there is no difference between government and non-government insurers regarding the made-whole laws.

Portions of the applicable statutes give the insurer an option to participate in the action against the tortfeasor. Respondents' contention this has relevance to certification, however, is incorrect on both on procedural and substantive grounds. Procedurally, the contention involves the merits – not class certification. Substantively, the contention lacks merit: Whether the insurer participates in the tort action or not, subrogation still "may not be enforced *until the injured insured has been fully compensated for the insured's injuries*." Section 2-18-902; § 33-30-1102, MCA (emphasis added).

4. Avoiding Coverage vs. Subrogation. Respondents attempt to distinguish traditional subrogation from the practice they are employing here.

Avoiding coverage because a tortfeasor is available to pay is "effectively [the] exercise of *subrogation* before paying anything . . . ." *Montana State Auditor*, *supra* at ¶ 19 (Emphasis added).

5. Factual Arguments. New West argues there is no evidence of "programmatic" conduct. Again, it needs to be emphasized that whether or not there exists "programmatic" conduct is one of the common factual issues on the merits. It is not part of the certification analysis. At any rate, the State's administrator admitted at the certification hearing that the State continues to assert the written exclusion that forces the tortfeasor to pay first. BCBSMT has essentially admitted to programmatic conduct by representing in *Neary* that certification is appropriate.

6. *Ferguson*. The State makes the representation that *Ferguson, supra*, is distinguishable because there was a "single plaintiff who had a single policy issued to a single insurance company." Ferguson, however, sued nine insurance companies no doubt having different plans. Her attorneys explained at page two of her opening appeal brief: "Each reference to 'Safeco . . . is a *reference to all defendant* insurance companies who implement a *common subrogation program* through Safeco Insurance Company of America." Likewise, here, the State and its two administrators are accused of engaging in a common scheme through multiple plans.

7. Rule 23(b)(3) Alternative. Most of the Respondents' contentions regarding the Rule 23(b)(3) alternative duplicate their other arguments. They bring up the amended complaint again, arguing that tort claims against BCBSMT and New West would defeat a class action. Suffice it to say that in *Ferguson, supra* at ¶ 6, the complaint "sought damages for violation of Montana's Unfair Trade Practices Act, breach of the insurance contract, constructive fraud, civil conspiracy, and aiding and abetting" and in *Burton, supra*, similar claims were made. Both were certified.

8. BCBSMT in *Neary*. BCBSMT advocated for and obtained preliminary Court approval of a class under Rule 23(b)(3). As addressed above, *Neary* only has two plaintiffs with two plans. Yet, virtually every Blue Cross plan in Montana is within the class – regardless of any differences among the class members.

IV. CONCLUSION

When the Respondents' confusing and often redundant arguments are eliminated, this returns to a straightforward class action suit.

Clearly, the class action should be certified against the State.

BCBSMT and New West will remain necessary parties, regardless of how this Court addresses their typicality contentions.

BCBSMT's contradictory position in *Neary* cannot be reconciled. If a class is appropriate in *Neary*, then a class is appropriate here. If in *Neary*, BCBSMT can identify class members (including those insured through the State), set forth the amount of benefits avoided and concede Rule 23(a) class requirements are met, then the same can be done here. If in *Neary*, BCBSMT can "ministerial[ly]" determine the amount due each individual class member without court assistance, then the same manageable remedy is available in this case.

Potential management problems ultimately arise in virtually all class actions. Rule 23 has several flexible solutions which have been referenced throughout this and the Opening Brief.

Therefore, the case should be reversed and remanded with appropriate orders.

DATED this 8th day of July, 2010.

THUESON LAW OFFICE

/s/ Erik B. Thueson

_____

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 (4)(d), MCA, I hereby certify that the foregoing document is double spaced, proportionately spaced, Times New Roman typeface, and 14 point size and less than 7,500 words.

DATED this 8th day of July, 2010.

/s/ Elayne M. Simmons

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CERTIFICATE OF SERVICE

I hereby certify that I served true and accurate copies of the foregoing document upon counsel of record by the following means:

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DATED this 8th day of July, 2010.

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